

Customer Choice
Home and Community Based Services
Frail Elderly
Money Follows the Person

Customer Name (First and Last)

Beneficiary Identification Number

The results of the functional assessment of my medical and personal needs indicate that I qualify for long term care services and those services essential to my health and welfare can be provided to me in my home or other community based setting within the program cost limits. **I have been informed that I am functionally eligible to receive services and may opt to remain in the community and receive the services as designated in the Plan of Care.** My signature below indicates I have been informed of this choice and have read my customer rights and responsibilities.

READ THE CUSTOMER RIGHTS AND RESPONSIBILITIES BEFORE PROCEEDING.

My choice is to: (check one)

- _____ Enter a Nursing Facility
- _____ Receive Home and Community Based Services as indicated on the Plan of Care
- _____ Receive Money Follows the Person Services as indicated on the Plan of Care
- _____ Refuse the Recommended Services

It is my choice: (check one)

- _____ To self-direct all or part of the services that are eligible for self-direction
- _____ Not to self-direct my services

I understand that upon my choosing to receive Home and Community Based Services I have:

- the option to self-direct all or part of the services that are eligible for self-direction,
- free choice of which provider(s) will provide my needed services, and
- free choice of the case management entity that will provide my targeted case management services.

Customer or Authorized Representative Signature

Date

Targeted Case Manager Signature

Date

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Reviewed Customer Choice Form:

Customer Initials:

Date:

TCM Initials:

Date:

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